

Map 10
(Rev 06/15)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
WAIVER SERVICES
PHYSICIAN'S RECOMMENDATION

PLEASE RETURN TO THE REQUESTOR LISTED BELOW.

(Requestor's Name)

(Address)

(City) **KY** (Zip) (Phone)

PHYSICIAN'S RECOMMENDATION

I recommend Waiver services for:

(Member)

(Medicaid Member ID #)

(Address)

(City) **KY** (Zip) (Phone)

DIAGNOSIS (ES):

Recommended Waiver Program:

- ☐ HCBW (APRN, PA or Physician signature)
☐ ABI Waiver – Services to adults with a **primary** diagnosis of an acquired brain injury (18 yrs and older) with a potential for rehabilitation and retraining (**Physician signature**)
☐ ABI Long Term Care Waiver – Services to adults (18 yrs and older) with a **primary** diagnosis of an acquired brain injury who has reached a plateau in their rehabilitation level and require maintenance services. (**Physician signature**)
☐ SCL Waiver (SCL IDP or Physician signature)
☐ Michelle P. Waiver – Non-residential Services to children and adults **with intellectual or developmental disabilities**.
(APRN, IDP, PA or Physician signature)

I certify that if Waiver services were not available, institutional placement in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with an Intellectual Disability shall be appropriate for this member.

(Authorized Signature)

(NPI #)

(Address)

(City) **KY** (Zip) (Phone)

(Date)

